Georgia Department Of Community Health
State Health Benefit Plan
Declination of Health Benefit Coverage

Please type or print clearly in ink

I. Employee/Member

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence

Date of Birth

Month	Day	Year

Daytime Telephone Number

( )

Area Code

Sex (Check one)

☐ Male ☐ Female

II. Department Information

Department or School System

Work Unit or School

When did you start working for the Department or School System?	Month	Day	Year

Please read the Terms, Conditions, and Instructions on the back of this form. Also carefully read the statement you check below. Your signature certifies that you understand that your subsequent enrollment with the State Health Benefit Plan will be restricted.

III. Statement and Certification (Check and sign only one statement)

☐ **Ineligible Employee**

I understand I am not eligible for coverage under the State Health Benefit Plan because by job is (check one):

- ☐ part-time
- ☐ seasonal
- ☐ intermittent
- ☐ temporary
- ☐ for an emergency period only

Employee Signature _____ Date _____

Declination by New Employee

☐ As a newly eligible employee, I do not choose to enroll in any option of the State Health Benefit Plan **because of other health insurance coverage.**

☐ As a newly eligible employee, I do not choose to enroll in any option of the State Health Benefit Plan **because of other reasons.**

I understand that if I decline coverage at this time, I cannot enroll for coverage under any option of the Plan until the next Open Enrollment period except under the conditions stated on the reverse side of this form. I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Employee Signature _____ Date _____

Note: Employees enrolled in the Plan transferring between school systems or departments or rehired within the same Plan Year (i.e., Jan 1 thru Dec 31) do not have the option of declining coverage during the Plan Year.

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

This form must be completed by a member/employee who declines coverage under the State Health Benefit Plan. Review the Statement and Certifications in Section III and sign the appropriate statement.

Enrollment in the State Health Benefit Plan

Enrollment in the State Health Benefit Plan is limited to the Open Enrollment Period, except under the following conditions:

- Upon employment, an employee has the opportunity to ENROLL for coverage to begin the first day of the month following completion of one full calendar month of employment, subject to the conditions of the Plan. See the State Health Benefit Plan booklet for pertinent conditions.

- Upon the loss of member's/employee's or dependent's health benefit coverage through Medicaid, Medicare, the group or COBRA coverage of the spouse or former spouse, a member/employee has the opportunity to **CHANGE** from Single to Family coverage provided the request is filed no later than 31 days following the event. (*Attach a letter from Medicaid, Medicare, or the spouse's or former spouse's employer giving the reason the group coverage was terminated, the type of coverage, and the date of coverage termination.)*

- Upon the acquisition of coverage under a new spouse's group plan or your spouse's employment, you may **CHANGE** to Single coverage or **DISCONTINUE** coverage provided all dependents covered under the SHBP contract are covered under the new contract. The request for the change of coverage must be filed within 31 days following the acquisition of other coverage. *(Attach a letter from the spouse's employer giving the date of employment, effective date of coverage, and name(s) of person(s) covered.)*

- Upon the acquisition of a dependent by marriage, birth, adoption, a qualified medical child support order (QMCSO) or for certain other changes in family status *(see the Eligible Dependents Section),* a **CHANGE** from Single to Family coverage is allowed provided the request is filed no later than 31 days following the event.

- Upon the loss of all eligible dependents, SHBP will automatically decrease coverage tier to employee only.

Open Enrollment Period

Open Enrollment is a time each year when active employees may enroll or **Change** option or type of coverage, subject to the provisions of the Plan. Active employees who are eligible to participate in the State Health Benefit Plan shall have an annual Open Enrollment period. The Open Enrollment period consists of a 15-day period beginning no earlier than Oct 15 and ending no later than Nov 30. Each year in advance of the period, the Commissioner of the Department of Community Health will announce the exact dates.

Note: Retirees may continue coverage at the time of retirement but are not allowed to enroll for coverage.